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June 23, 2006

**VIA HAND DELIVERY**

Alessandro A. Iuppa, Superintendent
Attn: Vanessa J. Leon
Docket No. INS-06-900
Maine Bureau of Insurance
34 State House Station
Gardiner, Maine 04333-0034

In Re: Review Of Aggregate Measurable Cost Savings Determined By Dirigo Health For The Second Assessment Year

**FILING COVERSHEET**

Dear Superintendent Iuppa:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach

DATE: June 23, 2006

DOCUMENT TITLE: Anthem BCBS Brief

DOCUMENT TYPE: Brief

CONFIDENTIAL: **NO**

Thank you for your assistance in this matter.

Very truly yours,

Christopher T. Roach

# NON-CONFIDENTIAL

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

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| IN RE: | ) | |
| | ) | |
| REVIEW OF AGGREGATE | ) | ANTHEM BCBS BRIEF |
| MEASURABLE COST SAVINGS | ) | |
| DETERMINED BY DIRIGO HEALTH | ) | |
| FOR THE SECOND ASSESSMENT | ) | |
| YEAR | ) | June 23, 2006 |
| | ) | |
| **Docket No. INS-06-900** | ) | |
| | ) | |

# NON-CONFIDENTIAL

## INTRODUCTION

Pursuant to the Superintendent's Notice of Pending Proceeding and Hearing dated April 26, 2006 and Order on Intervention and Procedures issued on June 15, 2006, Anthem Health Plans of Maine, Inc. d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS") submits this Brief.

The Board of Directors of the Dirigo Health Agency ("DHA Board" or "Board") has adopted for year 2 a methodology for calculation of aggregate measurable cost savings ("AMCS"), and resulting determination of AMCS, that are fundamentally flawed because (1) they are premised on an interpretation of the Dirigo Legislation that is so broad as to be without any meaningful limitation on the types of "savings" that may be included in the calculation of AMCS; and (2) within these broad categories of "savings" included in AMCS, the Board has accepted calculations from the Dirigo Health Agency ("DHA") that are unreasonable and, as a result, overstate AMCS. The result of these two fundamental flaws is a proposed calculation of AMCS for year 2 that is nearly identical to that found reasonable by the Superintendent in year 1, but in a year in which costs grew by more than triple the cost growth of measuring year 1. That calculation is not reasonable or reasonably supported by the record before the DHA Board.

In this year 2 proceeding, rather than limiting the categories of savings to those articulated in the Dirigo Legislation (*i.e.*, those resulting from the operation of the Dirigo Health Agency and expansions in MaineCare), the DHA Board has adopted a methodology that contains virtually no limits on the types of "savings" that may be calculated as having resulted from Dirigo. (*See, e.g.*, DHA Board Decision, Admin. Rec. ("A.R.") at 5288-89 ("Regardless of what certain individual legislators may have thought about how the Dirigo Health Program was to operate and be financed, the law, as enacted, in the Board's view, does not limit AMCS to those savings initiatives. Section 6913 only states that savings are to include any reduction or

avoidance of bad debt and charity care as a result of the operation of Dirigo Health and increased MaineCare enrollment; it neither limits savings to these initiatives nor expressly states what other initiatives may be considered by the Board in making its determination of AMCS.").)

The Board's interpretation is rather striking. Interpreting the Dirigo Act as containing a limitless standard of this sort is unreasonable, if not unconstitutional. *See, e.g., Shapiro Bros. Shoe Co., Inc. v. Lewiston-Auburn Shoeworkers Protective Ass'n*, 320 A.2d 247, 253 (Me. 1973) (to comply with due process a law "must provide reasonable and intelligible standards"; a statute "which would force men of general intelligence to guess at its meaning . . . and forc[e] courts to be uncertain in their interpretation of the law" is void for vagueness). The Board's interpretation thus would render the statute unconstitutionally vague.

The Superintendent determined last year that he would not re-visit the legal interpretations of the DHA Board and, while Anthem BCBS understands that the legal parameters of the DHA Legislation are before the Courts of this State, it is difficult to understand how the Superintendent can determine what amount of aggregate measurable cost savings are reasonably supported by the record without identifying whether the parameters for those alleged savings are properly within the statute the Superintendent is attempting to apply. The AMCS is supposed to be comprised of cost savings that are the result of the operation of Dirigo Health and expansions in MaineCare. *See* 24-A M.R.S.A. § 6913(1). The DHA Board's suggestion that the Legislature provided in the Act only a floor on what may be counted as AMCS, but with no ceiling, is contrary to the plain language, is unreasonable and should be rejected. *See, e.g., Small v. Maine Bd. of Registration and Examination in Optometry*, 293 A.2d 786, 788 (Me. 1972) ("In order to avoid an unlawful delegation of power, the legislative authority must . . . fix the legal principles which are to control in given cases by setting up standards or guides to indicate the extent, and prescribe the limits, of the discretion which may be exercised under the statute or

ordinance by the administrative agency."); *Wakelin v. Town of Yarmouth*, 523 A.2d 575, 577 (Me. 1987) (declaring municipal zoning ordinance to be unlawful due to the "absence of standards to control the authority delegated to the [Zoning] Board").

Factually, this broad (indeed limitless) reading by the DHA Board led to a calculation of AMCS that is not reasonably supported by the evidence in the record. More specifically, in the proceedings for calculation of the AMCS for year 1, hospital costs grew from the prior year by 1.93% and the Superintendent found $43.7 million of the DHA Board's suggested $133 million to be reasonably supported by the evidence in the record. The DHA Board adopted a methodology for year 2 that produces nearly that same level of AMCS ($41.7 million),[1] but in a year when cost growth was more than triple that of year 1. (*See* Anthem BCBS Hearing Exhibit 8 ("Exhibit 8"), A.R. at 3466 (reflecting that, according to DHA's data, hospital costs for state fiscal year 2005 grew by 6.85%, as compared to 1.93% cost growth for SFY 2004).)[2] Even if it were otherwise reasonable to adopt a methodology that is limitless on what may be counted as "savings" (which it is not), it is unreasonable to calculate essentially equivalent levels of AMCS for two years in which cost growth more than tripled from one to the next.

The question then becomes, how did the Board come up with over $40 million in cost savings in a year in which cost growth has accelerated so significantly? The answer is that the methodology adopted by the Board significantly overstates savings:

- Certificate of need ("CON") savings are calculated for future years where none of the dollars associated with this "savings" have been or were to be spent in the measuring year (SFY 2005) and, in any event, are duplicative of savings counted in the cost per case mix adjusted discharge ("CMAD") calculation;

[1] The AMCS proposed by DHA's consultant, Mercer Government Human Services Consulting ("Mercer"), was $100 million for year 2. *See* Dirigo Health Savings Offset Payment: Year 2—Methodology Update and Preliminary Calculation ("Updated Mercer Report"), A.R. at 1080.

[2] For the convenience of the Bureau, Attachment 1 is a copy of Anthem BCBS's Exhibit 8.

- CMAD savings are included for a year in which cost growth is well in excess of historical averages and for which there is no voluntary cost growth target in the Dirigo Act in the first place;

- Uninsured initiatives adopted by the Board treat those who were DirigoChoice members during the first measuring year as though they had no insurance in year 1 and, accordingly, counts those members again for the uninsured initiatives for year 2, notwithstanding that those members were not, in fact, uninsured;

- The full dollar amount of increases in periodic interim payments ("PIP payments") to hospitals are counted, notwithstanding that (1) the State remains overdue in its payments by more than $200 million (*see, e.g*., Hearing Testimony of Steven Michaud ("Michaud"), A.R. at 5146, Tr. 65, lns. 5-12), (2) the unrebutted testimony of Steven Michaud, head of the Maine Hospital Association ("MHA"), demonstrates that increases in PIP payments are not related to Dirigo, and (3) in any event, at most 4% of the PIP payments legitimately increase hospital cashflow, which means that at most 4% of the PIP payments could actually reduce cost shifting (*see* Prefiled Testimony of Steven R. Michaud ("Michaud Prefiled"), A.R. at 4312, lns. 3-23);[3]

- The full dollar amount of physician fee increases are counted under the unreasonable presumption that every dollar of physician fee increases will result in a dollar reduction in each physician's charges, thereby negating entirely the fee increase in the first place; and

- Instead of using consistent time periods from which to measure cost savings as the Superintendent directed in the Decision and Order from year 1, the Board adopted a methodology that continues to measure savings in different time periods and then adjusts the calculation by applying an interest factor, as though that were equivalent to measuring cost savings from consistent time periods.

In addition to these calculation flaws, as was the case last year, neither Mercer nor DHA made any effort whatsoever to determine what of the calculated amounts (if any) actually resulted from the operation of Dirigo Health, or even more broadly, whether any of the amounts were actually attributable to any Dirigo initiative. Instead, whatever numbers emanated from these calculations were simply deemed included within AMCS.

These broad assumptions should be unacceptable, but particularly so given the thousands of Mainers with private insurance who must pay the savings offset payment ("SOP").

[3] Mr. Michaud's prefiled testimony is Attachment 2 to this Brief.

In this methodology and calculation, the Board is asking the Superintendent to suspend reality. To approve a calculation that includes a determination that withdrawal or modification of future CON projects result in current year cost savings; where there is no concern about including duplicative cost savings; where those who have insurance somehow can be defined as uninsured; and where we are unconcerned about whether or not the calculated savings actually (rather than theoretically) reduce cost shifting because that's the job of the market participants. The drive to attribute as much as possible to Dirigo to increase subsidies is much like the euphoric purchase of some item using a credit card, but without the realization that someone (in this case, all of those with private insurance) will have to pay the bill. The citizens of Maine who pay that bill deserve no less consideration and equity than those who benefit from the subsidies provided by the SOP.

Mercer testified that one of its guiding principles was that the Dirigo program should be self-funded by the savings it generates, "at no additional cost." Anthem BCBS strongly agrees with this guiding principle, but the methodology and resulting calculation of AMCS presented by the Board do not adhere to this guiding principle and are, for all of the reasons set out above and in this Brief in more detail below, not reasonably supported by the record.

## ARGUMENT

### I. Procedural Flaws

The procedures employed by the Board during this proceeding did not comport with the Maine Administrative Procedures Act or traditional notions of the most basic due process. The inadequacies are numerous and are set forth, among other places, in Anthem BCBS's prehearing brief before the DHA Board and the intervenors' Rule 80C petition, filed with the Superior Court following the Board's refusal to hold a hearing or issue a decision no later than April 1st in compliance with the requirements of the Dirigo Act. The Rule 80C petition, attached hereto

(Attachment 3), summarizes the inadequacies of the Board's procedures in this matter and Anthem BCBS will not repeat them here. Suffice to say that the process chronicled therein is not consistent with (if not contrary to) the manner in which the Superintendent conducts adjudicatory proceedings.

It is challenging enough to present a case to a Board that has a significant interest in generating funding for that Board's program. The un-even and imbalanced process that exemplified the proceedings before the Board made a challenging process all that much more difficult and led to a decision without providing the intervenors with a fair opportunity to be heard meaningfully on fundamental issues.

Anthem BCBS does not expect the Superintendent to grant relief from these procedural flaws, but believes that the light in which the Superintendent reviews the record and determinations by the Board should be informed by the context in which the proceeding was run.

## II. Global Substantive Flaws In The Board's Recommended Methodology

For the second assessment year, DHA presented and the DHA Board adopted a methodology for calculating savings for four initiatives: Hospital Savings Initiatives, Uninsured Savings Initiatives, Certificate of Need and Capital Investment Fund Initiatives, and Health Care Provider Fee Savings Initiatives.[4] Anthem BCBS's specific concerns with each of these initiatives are described later in the Brief, but more globally, the Board-recommended methodology is inappropriate because it (1) sets no limit on the types of "savings" that may be included in the AMCS calculation; (2) deviates significantly from the actual hospital cost growth

[4] Arguments concerning whether any savings other than the uninsured initiatives may be included in AMCS are currently on appeal and Anthem BCBS incorporates by reference the arguments intervenors have made in those appeals. *See Maine Auto. Dealers Ass'n Ins. Trust v. Superintendent of Ins.*, Docket No. AP-05-74; *Maine State Chamber of Commerce v. Superintendent, State of Maine Bureau of Ins.*, Docket No. AP-05-75; *Maine Ass'n of Health Plans v. Superintendent, Bureau of Ins.*, Docket No. AP-05-90; *Maine Ass'n of Health Plans v. Dirigo Health Agency*, Docket No. AP-05-94.

experienced by Maine hospitals, meaning that "savings" can result in a year with significantly accelerated cost growth; (3) assumes that private payers can recoup 100% of any cost savings determined to result from Dirigo Health despite the fact that private payers account for less than 40% of Maine's hospital utilization and associated revenue; and (4) fails to adhere to DHA's guiding principle that the calculation would result in funding the Dirigo program "at no additional cost".

### A. The Board-Recommended Methodology Sets No Limit For The Types Of Savings That May Be Included In AMCS.

On its face, the Dirigo legislation limits the types of savings that can be included in the AMCS calculation to (1) "increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004", and (2) "cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health." 24-A M.R.S.A. § 6913(1)(A). While DHA seems to acknowledge the latter requirement in Mercer's "guiding principles" to the year two methodology (*see, e.g.*, Amended Pre-filed Testimony of Stephen P. Schramm ("Schramm Prefiled"), A.R. at 1258, lns. 109-10 ("the methodology must be reasonable and appropriately measure the impact of Dirigo on the rate of growth in the health care system")), the methodology ultimately put forth by DHA and recommended by the Board does not adhere to this principle.

Instead, the Board has adopted a methodology that interprets the Act as containing only a floor on what may be considered in the calculation of AMCS, with no upper limit at all, in spite of the plain language and significant legislative record to the contrary. (*See, e.g.*, Chamber Hearing Exhibit 21—Legislative History, A.R. at 4731-87 (referencing that the Dirigo program would be funded via reductions in bad debt and charity care costs).) The Superintendent should not perpetuate this unreasonable interpretation because it leads to AMCS calculations that are not reasonably supported by the record.

### B. Putting To One Side The Limitless And Unreasonably Broad Interpretation Of The Dirigo Act, The Board's AMCS Calculation Is Not Reasonably Supported Because It Results In Significant "Savings" In A Year With Accelerated Cost Growth.

The unreasonableness of the Board's proposed methodology is exposed by simply looking at its AMCS calculation for the second assessment year and comparing that to what the Superintendent found to be reasonable in last year's proceeding.

For the first assessment year (SFY2004), a year in which actual costs increased by 1.93% over the prior year, the Superintendent determined that the record reasonably supported a savings of $43.7 million. (S*ee* Attachment 1, Exhibit 8, A.R. at 3466.)

Using Mercer's data, Maine hospital costs in any year are expected to grow by 1.93% above the applicable hospital market basket index ("HMBI"). (*See* Updated Mercer Report, A.R. at 1094; *see also* Hearing Testimony of Stephen Schramm ("Schramm"), A.R. at 5123, Tr. 127, lns. 15-18.) For the present measuring period, SFY 2005, this translates into an estimated expected cost growth of 6.24% (HMBI of 4.22% and 1.93% above inflation = 6.24%). (*See* Attachment 1, Exhibit 8, A.R. at 3466.)

Stephen Schramm, DHA's lead expert, conceded these points at the hearing:

> Q. The rate that you have calculated that costs in Maine, hospitals grow above the market basket inflation rate historically pre Dirigo is 1.93; is that right?
>
> A. Correct.
>
> Q. That comes directly from [Mercer's] Appendix D?
>
> A. Yes.
>
> Q. Subject to check, would you accept that the aggregate of those two figures is 6.24 percent?
>
> A. Correct.
>
> Q. So that's the rate by which historically we would have expected costs to grow from one fiscal year to the next, correct?
>
> A. Correct.

(Schramm, A.R. at 5123, Tr. 127, ln. 21 – Tr. 128, ln.2.)

In SFY2005, however, actual costs grew by 6.85%. In other words, cost growth in SFY 2005 accelerated significantly from SFY 2004; more than tripling that year's cost growth and rising significantly above the expected cost growth projected using Mercer's historical data.

Notwithstanding this tripling of cost growth from the 2004 to 2005 assessment periods, the methodology championed by DHA for the second assessment year produced a savings figure of $100 million when applied to the year two data, more than double that of the prior year. (*See* Updated Mercer Report, A.R. at 1080.) In fact, Mr. Schramm admitted that Mercer's methodology would produce "savings" for any level of cost growth less than 10.26%, a percentage of cost growth greater than any of the years of historical data used to develop the methodology in the first place:

> Q. And we have your estimate of the state fiscal year CMAD for 2005 of 6,518. That comes from your Appendix D, right?
>
> A. Correct.
>
> Q. Subject to check, would you agree that that would be an increase of 10.26 in cost growth from state fiscal year 2004 to state fiscal year 2005?
>
> A. Yes.
>
> Q. Does that then mean that any increase in costs below 10.26 percent for state fiscal year 2005 would result in a positive savings under your methodology?
>
> A. Yes.
>
> . . .
>
> Q. That means that your savings methodology would calculate a savings even if the growth rate from 2004 fiscal year to 2005 was higher than the highest growth rate using the historical data; is that right?
>
> A. Yes.

(Schramm, A.R. at 5123-24, Tr. 128, lns. 6 – 17; Tr. 129, lns. 4-8; *see also* Attachment 1, Exhibit 8: Table labeled "Historical and Current Cost Growth Above/Below Inflation", A.R. at 3466.)

While the Board reduced Mercer's CMAD calculation from $69 million to $14.5 million, the Board did so when finding persuasive that the historical mean cost growth was more

reasonably 4.7%. (*See* DHA Board Decision, A.R. at 5294.) In spite of this determination, the Board found $14.5 million in CMAD "savings" when actual costs grew by 6.85%, more than two percentage points higher than the historical mean that the Board found reasonable. That "savings" can result in a year in which hospital cost growth increases at a significant rate above historical averages and the historical mean is both counterintuitive and irrational.

### C. The Board-Recommended Methodology Fails To Account for The Fact That More Than 50% Of Hospital Revenues Are Paid By Governmental, Not Private, Payers.

The flaws in the Board's proposed methodology are compounded by the fact that the Board counts its savings across all payers even though MaineCare and Medicare account for more than half of all hospital utilization and hospital revenues in Maine and there is no adjustment in the Board's methodology to adjust for that uncontroverted fact. MHA president Steven Michaud testified in the proceeding before the DHA Board that MaineCare and Medicare account for approximately 60 percent of utilization at hospitals in Maine, and around seven percent of hospital utilization is related to those without insurance, thereby leaving less than 35% of utilization and associated revenue that is applicable to private payers. (Michaud, A.R. at 5147, Tr. 70, ln. 23 – Tr. 71, ln. 7; *see also* Hearing Testimony of Thomas Drottar, A.R. at 5174, Tr. 180, lns. 18-25 (stating that a reduction of discharges of 60% to account for governmental payers would result in a calculation of savings reduced by a directly proportional amount); Anthem BCBS Hearing Exhibit 15, A.R. at 3619.)

Mr. Schramm also conceded that Mercer's calculation of cost per CMAD included public payer discharges (Medicare and Medicaid) and uninsured patients, and Mercer made no adjustment for this fact:

> Q. . . .I am going to ask you, though, whether the discharge number, 344,711, includes patients that would have been covered by Medicare?
>
> A. Yes.

Q. Does the 344,711 include patients that would have been covered by Maine Care?

A. Yes.

Q. And . . . [i]t would also include discharges related to those who were uninsured, right?

A. Yes.

Q. Did Mercer make any adjustment in its methodology, yes or no, for the fact that there were discharges included in the methodology that were related to Maine Care, the uninsured or Medica[re]?

A. No.

(Schramm, A.R. at 5125-26, Tr. 136, ln. 12 – Tr. 137, ln. 5.)

It perhaps goes without saying that it is both inequitable and inappropriate to require the already-burdened private payers to pay an SOP that is based on savings that are attributable to dollars that are paid by governmental payers, but that is exactly what will happen under the Board's recommended methodology. The amount of AMCS, if any, that the Superintendent deems supported for year 2 should be reduced by the percentage attributable to public payers and to the uninsured, the facts of which went unrebutted at the hearing.

### D. The Board-Recommended Methodology Fails To Provide A Mechanism To Determine Whether Calculated "Savings" Are Actual Savings Experienced By Maine Hospitals And Thereby Fund The Dirigo Program "At No Additional Cost."

Mercer conceded one guiding principle in development of a methodology for calculation of AMCS is that savings should be limited to those that reduce cost shifting to private payers, or otherwise lower the costs for the private payers who pay the SOP. (*See, e.g.*, Schramm Prefiled, A.R. at 1258, lns. 115-16 ("When calculated, the savings will be used to sustain DirigoChoice at no additional costs.").)[5] Tacitly conceding the importance of this guiding principle, Mercer

[5] This is consistent with the statutory construct. The intent of the Dirigo Act regarding the savings determination is clear; as the name implies, the savings offset payment is designed to offset savings as a result of the operation of Dirigo Health. For that reason, calculation of AMCS is supposed to capture only the actual reduction in cost shifting, which reduction private payers return to DHA in the form of the (*footnote continued on next page*)

actually considered not just communicating, but actually negotiating, with hospitals to reach agreement on the level of cost savings that could be attributed to Dirigo:

> Q. . . . Mr. Stiles asked whether you had contacted any of the hospitals or the hospital association to try to verify your savings methodology, right?
>
> A. Correct.
>
> Q. And you did not do that?
>
> A. We did not.
>
> Q. You did contemplate doing that though, right?
>
> A. We thought about alternative methodologies, and I believe that was one of the ideas that was discussed.
>
> Q. In fact, did you contemplate negotiating with the hospitals ahead of time to try to determine what costs to be attributed to Dirigo?
>
> A. I don't think so.
>
> Q. Could I ask you to turn in the larger exhibit, Exhibit 7, Anthem Exhibit 7?
>
> A. Yup.
>
> Q. Find bates Page 424, Mercer 424.
>
> A. Yes.
>
> . . .
>
> Q. This is a Mercer meeting note; is that right?
>
> A. Yes.
>
> Q. So this would have been written by a Mercer employee?
>
> A. Yes.
>
> Q. The note reads "how do hospitals show that cost savings/changes are attributable to Dirigo? Is there incentive for them to do so?" . . . The note goes on then to say "may need to negotiate up front with hospitals and come up with a method to say what is or isn't attributable to Dirigo."
>
> Did I read that correctly?
>
> A. You did.

---

(*continued footnote*)
SOP. Anthem BCBS has no difficulty with this concept and has long advocated that the AMCS calculation should provide the symmetry envisioned by the Dirigo legislation and establish as savings only those cost reductions that have actually inured to the benefit of the private payers who will pay the SOP.

(Schramm, A.R. at 5122, Tr. 121, ln. 16 – Tr. 123, ln. 2 (emphasis added).)

In the end, Mercer neither communicated (nor negotiated with) hospitals to determine what if any cost savings calculated for year 2 were actually attributable to the operation of Dirigo Health. Instead, the methodology simply deems 100% of any calculated cost savings as having been the result of Dirigo, and further presumes that this 100% of cost savings is available to reduce hospital charges. In so doing, the methodology adopted by the Board fails to adhere to the guiding principle that the AMCS calculation should result in Dirigo being funded "at no additional cost."

Importantly, this conclusion does not require the Superintendent to make any legal interpretation of the Dirigo Act at all. To the contrary, Mercer, DHA and now the Board by adopting the Mercer methodology, have interpreted the law as requiring a calculation that results in funding the Dirigo program at no additional cost. The Superintendent now should look at the factual record to determine whether the Board's recommended calculation actually results in funding at no additional cost.

Given Mr. Schramm's testimony, this is not a difficult factual finding to make because the record on this point is affirmatively bereft: other than considering trying to negotiate some deal to attribute savings to Dirigo, Mercer made no effort to determine whether, and if so to what extent, hospitals actually achieved cost savings in SFY 2005 and, instead, simply deemed all calculated costs to be AMCS that are Dirigo related. In so doing, Mercer, DHA and now the Board, have adopted a calculation that violates their own test. The Superintendent, accordingly, should reject the resulting calculation.

## III. Flaws Specific To Individual Savings Initiatives Recommended By The Board

### A. Hospital Savings Initiatives (CMAD)

#### 1. Any Savings Captured By The CMAD Calculation Are Not Attributable To The Operation Of Dirigo Health.

As recounted above, the Dirigo Legislation limits savings included in the AMCS calculation to those savings attributable to the operation of Dirigo Health. For the first assessment year, the Board asserted that its proposed CMAD savings were a result of Dirigo because they arose from the voluntary limitations specified in part F(1)(B) of the Dirigo Health legislation, enacted as Public Law 2003, chapter 469, which reads:

> B. Each hospital . . . is asked to voluntarily restrain cost increases, measured as expenses per case mix adjusted discharge, to no more then 3.5% for the hospital fiscal year beginning July 1, 2003 and ending June 30, 2004. Each hospital is asked to voluntarily hold hospital consolidated operating margins to no more than 3% for the hospital's fiscal year beginning July 1, 2003 and ending June 30, 2004.

P.L. 2003, c. 469.

Anthem BCBS disagrees that the inclusion of savings from CMAD in last year's AMCS determination was appropriate, but even assuming that chapter 469 provided some basis for inclusion of CMAD in year one, that statute, by its own terms, does not apply to the second assessment year. Likewise, there are no other statutory limits, voluntary or otherwise, relating to CMAD for the second assessment year. Counsel for the DHA Board acknowledged this fact prior to the Board's determination and that acknowledgement is part of the record before the DHA Board. (*See* Mercer notes, A.R. at 3026 (when discussing whether DHA could argue that CMAD could be included in AMCS for year 2 because of the MHA's voluntary cap, Counsel to the DHA Board warned that "we may lose under appeal for year 1 since voluntary & not due to Dirigo – have letter that says they will comply to target but no link to Dirigo").)

Notwithstanding the lack of a statutory basis and its own counsel's admonition, the Board included CMAD savings again this year in the calculation of AMCS, determining that any cost reductions resulting from the MHA's request for a voluntary limit of 4.5% on cost increases in CMAD among Maine hospitals were a result of the operation of Dirigo Health.

The Board's finding that Dirigo Health caused the voluntary cap established by MHA simply ignores the uncontested evidence. MHA president Steven Michaud, who offered the only testimony on this point, stated without equivocation that the 4.5% voluntary cap on hospital costs had nothing to do with the Dirigo legislation. (*See* Michaud Prefiled, A.R. at 4310, lns. 18-23, 4311, lns. 3-9; Michaud, A.R. at 5149, Tr. 79, lns. 19-20 ("the voluntary cost targets in year 2 are unrelated to Dirigo").) Instead of accepting this unequivocal testimony from the MHA's highest official that the voluntary cap was not the product of Dirigo, the Board cast it aside and, instead, simply deemed it to be so. Given that Mr. Michaud is the head of the association that proclaimed the voluntary cap on hospital spending, the Board's determination is not supported by the evidence in the record.

In addition to being unrelated to Dirigo Health, the 4.5% voluntary cap advocated for by MHA played no role in the DHA methodology. Moreover, with average cost growth of 6.85% for SFY2005, it appears that hospitals did not view the cap as anything other than an internal aspirational goal.[6] In any event, attributing "savings" to a voluntary cap growth figure that was not in the Dirigo Act and in practice was exceeded by more than 50% is unreasonable, and even

[6] Mr. Schramm conceded that he was unaware of any power MHA would have to enforce a voluntary cost cap on hospitals:

> Q. Do you know whether the Maine Hospital Association has any power to impose any type of limit on member hospitals?
>
> A. I do not know.

(Schramm, A.R. at 5125, Tr. 136, lns. 5-8.)

less supportable given that Mercer and DHA made no effort to determine whether these "savings" were actually achieved and, if so, whether they were as a result of the operation of Dirigo Health (which the record, through the testimony of Mr. Michaud and views of the Board's own counsel, reflects they clearly were not).

### 2. The CMAD Methodology Proposed By The Board Fails To Produce Reasonable And Credible Results.

To the extent that savings from CMAD are determined to result from the operation of Dirigo Health, neither the methodology proposed by DHA, nor that eventually adopted by the Board, provides an appropriate mechanism to measure those savings.

The Mercer methodology for the second assessment year calculates CMAD savings by starting with the actual SFY2003 CMAD, but then ignores the actual SFY 2004 CMAD and, instead, projects SFY2005 CMAD by trending the actual SFY2003 forward two years. The analysis then calculates the savings per CMAD as the difference between the projected and actual figures, and the savings per CMAD is then multiplied by the total Maine hospital case-mix adjusted discharges to arrive at a final savings number. This calculation assumes (incorrectly) that costs in SFY2004 increased by their historical average (rather than using the actual costs for SFY2004), and then projects SFY2005 costs based on the projected SFY2004 costs, rather than the actual costs for SFY2004. This led to Mercer's faulty assumption that any cost increase below 10.26% for SFY2005 would result in "savings."

Mr. Schramm testified that Mercer's year 2 methodology was "conservative", suggesting that using for year 2 the methodology approved by the Superintendent in year 1 would produce a higher AMCS than calculated by the Mercer methodology. (*See* Schramm, A.R. at 5020, Tr. 191, lns. 5-12.) Application of the proposed year 2 methodology to year 1, however, belies Mr. Schramm's suggestion that the Mercer year 2 methodology is conservative.

More specifically, when the data from the year 1 assessment is calculated using the year 2 methodology proposed by Mercer, the result is a CMAD "savings" figure of $76.5 million; a calculation that is more than double the $33.6 million that the Superintendent found supported by the record for the first assessment period. (*See* Anthem BCBS Exhibit 9, A.R. at 3467; Hearing Testimony of William Whitmore, A.R. at 5177, Tr. 189, lns. 3-5) This result was not contradicted by anyone at DHA or Mercer.

The Board voted 3-0 to adopt the Mercer CMAD analysis, but to calculate savings by projecting growth for 2005 using the median historical growth rate for years 1999 to 2003 (*i.e.*, 4.7%), an approach outlined in the testimony of the Chamber's expert, John Sheils. (*See* Chamber Exhibit 21, Table 7, A.R. at 4693.) Although the CMAD calculation dropped from $72.7 to $14.5 million under the Board's hybrid analysis, the Board's attempt to produce a more "conservative" savings figure suffers from the same flaw as the original Mercer approach in that it results in "savings" in a year when actual cost growth (6.85%) significantly exceeded the historical median (4.7%). As explained numerous times above, finding "savings" in a year in which hospital costs substantially accelerate reveals that the proposed methodology is seriously flawed.

Moreover, Mercer conceded from the beginning that they did not have the qualifications or expertise to interpret and use Medicare cost reports ("MCRs") in the development of the CMAD methodology. (Dirigo Health Savings Offset Payment: Year 2—Methodology and Data Sources, A.R. at 203 ("Mercer is not an expert in Medicare Cost Reports").) Mercer also made clear that they wanted an expert who, similar to Dr. Kane from the year 1 case, had prior

experience with Maine and Maine hospitals. (Schramm, A.R. at 5126, Tr. 140, ln. 18 – Tr. 141, ln. 4.)[7]

Despite the repeated warnings noted in the Mercer documents of the need for an MCR expert, Mercer did not retain a qualified MCR expert to assist in developing the year 2 methodology, but instead developed the methodology in-house without expert guidance and using Mercer employees who, by their own admission, did not know how to use the MCR reports and, instead, simply tried to follow what Dr. Kane had done the previous year. (*See* Mercer email, A.R. at 3266.)[8] Mercer had many questions on how to use the reports; questions that went unanswered by anyone with the appropriate qualifications. (*See id.*, A.R. at 3266-67 (reflecting

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[7] Several internal Mercer communications made during the development of the year 2 methodology highlight the urgency of their need for an MCR expert with Maine experience. (*See, e.g.*, Mercer notes, A.R. at 3431, 3444, 3445, 3446, and 3448.)

[8] In addition, Mercer was advised by Nancy Kane, the medicare cost report expert from year 1, that hospital financials are complicated and that her husband was available to assist if DHA desired to contract with him. Notwithstanding this advice, DHA retained no hospital financials expert:

> Q. Can you turn to, in Exhibit 7 again, Page 1028? This is an e-mail from Tim Doyle [of Mercer] to you dated March 14, 2006 --
>
> A. Yes.
>
> . . .
>
> Q. This is an e-mail regarding a telephone conversation that Mr. Doyle apparently had with Nancy Kane, right?
>
> A. Yes.
>
> Q. She's talking about hospital audited financials and mentioning that her husband is the expert?
>
> A. Yes.
>
> Q. She mentions that financials are not straightforward and she gives some reasons and that her husband would be available to contract with if the state wanted to contract with him for that service; is that right?
>
> A. Correct.
>
> Q. And the state did not contract with Ms. Kane's husband; is that right?
>
> A. We did not.

(Schramm, A.R. at 5127, Tr. 141, ln. 8 – Tr. 142, ln. 4.)

the substantial questions Mercer analysts had concerning how use the MCRs).) Moreover, Mercer modified the CMAD approach rather significantly from the year 1 methodology, creating a so-called aggregate CMAD against which to measure cost growth, and doing so without Dr. Kane or a replacement expert upon which to rely.

After the methodology was developed and the calculations completed, Mercer did retain Leonard Brauner, an expert in hospital cost reporting, a mere two weeks prior to the hearing before the Board. (Hearing Testimony of Leonard Brauner ("Brauner"), A.R. at 5102, Tr. 43, lns. 19-23.) Mr. Brauner, however, did not assist Mercer in developing the year 2 methodology or performing the savings calculation, nor did he review the methodology for reasonableness. (*Id*., A.R. at 5101, Tr. 39, lns. 18-21; *see also* Schramm, A.R. at 5125, Tr. 135, lns. 10-17 (conceding that methodology was developed prior to retention of Mr. Brauner and Mr. Brauner did not review or opine on whether the methodology was appropriate).) Rather, his sole task was to determine whether the data used from the MCRs by Mercer to calculate the CMAD figure came from the proper source within the cost reports. (Brauner, A.R. at 5101, Tr. 40, lns. 3-8; Prefiled Testimony of Leonard Brauner, A.R. at 1284, lns. 45-47.) Indeed, Mr. Schramm testified that Mercer made no adjustments to the CMAD calculation in response to Mr. Brauner's review, with the exception of confirmation that graduate medical education costs were excluded. (Schramm, A.R. at 5127, Tr. 142, lns. 10-21.) It was evident from the testimony that Mr. Brauner's review was minimal:

- Mr. Brauner did not review the entries from the MCRs used in calculating the CMAD to ensure their accuracy, as he was "instructed not to do that." (Brauner, A.R. at 5101, Tr. 40, lns. 15-18);
- He did not audit the numbers, (*id*., A.R. at 5102, Tr. 41, lns. 22-24);
- He did not even perform a random sample to check for accuracy, (*id*., A.R. at 5107-08, Tr. 64, ln. 24 – 65, ln. 10); and
- He did not review or verify that the errors found in Dr. Kane's spreadsheets in year 1 were corrected, (*id*., A.R. at 5102, Tr. 42, lns. 3-11).

Had Mercer desired that Mr. Brauner review the actual methodology, it is questionable whether he would have had the expertise to do so. As Mr. Schramm testified, Mr. Brauner was hired to work on the Dirigo project despite the fact that he did not have the experience with Maine hospitals that Mercer thought critical to the job. (Schramm, A.R. at 5127, Tr. 141, lns. 5-7; Brauner, A.R. at 5102, Tr. 43, lns. 21-23 (acknowledging that prior to his engagement by Mercer, he had no familiarity with the Dirigo Health Act and had no experience whatsoever with Maine hospitals).)

In the absence of an expert that Mercer acknowledged was critical to the process, the Board cannot meet its burden to show that its CMAD methodology and calculation are reasonably supported by the evidence in the record.

### B. Certificate of Need and Capital Investment Fund (CON/CIF)

#### 1. The Savings Calculated From The Board-Recommended CON/CIF Methodology Are Not Attributable To The Operation Of Dirigo Health And, In Any Event, Are Duplicative Of CMAD Savings.

For the reasons set forth above, the savings calculated from the Board-recommended CON/CIF methodology do not result from the operation of Dirigo Health and thus have no basis to be included in the AMCS calculation. However, even if CMAD and CON savings otherwise may be included in AMCS, the CON measure should not be included in AMCS because it is duplicative of the proposed CMAD measure. Put differently, all hospital costs are included in the CMAD methodology, including those costs associated with CON projects. As such, any increase or decrease in CON-related costs is already reflected in the CMAD calculation; including those changes in a CON measure as "savings" would be double counting.

DHA, through Mercer, tries to avoid the implications of this double-counting in its year 2 methodology by measuring CON savings for a time period different than that in which it measures savings from CMAD: "the CON calculation is for a different time period [than

CMAD], and so there is no overlap and no need for control during the calculation." (Schramm, A.R. at 5136, Tr. 25, lns. 13-16.) Measuring savings from CMAD and CON in different time periods, however, does not erase duplication; it just extends the redundancy into future years. As conceded to by Mr. Schramm, any CON savings for 2006 will be embedded in a future CMAD calculation. (Schramm, A.R. at 5143, Tr. 54, lns. 21-24; *see also* Michaud Prefiled, A.R. at 4314, lns. 7-9 ("Any modification that lowers the operating cost of a CON approved project would begin to be seen in the hospital's CMAD calculation in the first year that the project begins to show operating costs.").)

In addition to being duplicative, the proposed CON measure is contrary to the Superintendent's directives to count only savings achieved during the assessment period and to calculate savings on a common time period basis. For example, in the first assessment year, the Superintendent denied the inclusion of increased PIP and physician payments during CY2006 in the AMCS calculation because "the savings offset payments will be levied during CY2006 and should correspond to savings that have already been achieved and measured." (First Assessment Year Decision and Order, Docket No. INS-05-700, A.R. at 4727.)

For the same reasons, future projected CON/CIF savings should not be counted in this proceeding. Applying an interest factor to different time periods does not remedy this nonconformance with the Superintendent's first year order, and in any event is not equivalent to measuring cost savings from the same time period. (Hearing Testimony of Jack Keane ("Keane"), A.R. at 5178, Tr. 194, lns. 15-23; *see also* Mercer notes, A.R. at 3026 (Counsel to the DHA Board instructed that savings should be measured using "a consistent time period").)

In deciding to adopt DHA's proposed CON/CIF analysis, the Board dismissed Anthem BCBS and other interveners' claims that CON/CIF savings were duplicative and not attributable to Dirigo Health. In so doing, the Board noted the absence of any evidence contradicting the

assumptions utilized by Mercer in its analysis, specifically the absence of any testimony from Mr. Michaud or the affected hospitals that the CON/CIF calculated savings were not as a result of Dirigo. (DHA Board Decision, A.R. at 5297.) In so doing, however, the Board turns the proper burden of proof in this proceeding on its head, *i.e.*, creating a presumption that 100% of any "savings" found are both proper and attributable to Dirigo unless proven otherwise. Even if it were intervenors' burden to prove duplication and inconsistency with the Dirigo Act (which it is not), given that the Board ignored Mr. Michaud's testimony concerning the MHA's motives behind the 4.5% voluntary cap, it is specious to suggest that all intervenors had to do to rebut the CON/CIF analysis was to offer testimony from Mr. Michaud on this point.[9]

### 2. The Board-Recommended CON/CIF Methodology Fails To Produce Reliable And Credible Savings Figures.

Even if it were determined that costs saved from CON projects have sufficient statutory basis for inclusion in the AMCS calculation, the methodology recommended by the Board to calculate these savings is inappropriate. In short, the Mercer methodology adopted by the Board calculates savings that result from withdrawal or modification of CON projects, calculated using the original CON application as filed. As such, this measure necessarily presupposes four conditions that are at best speculative, and more likely, almost certain not to occur. Those speculative results are that: (1) CON projects will proceed precisely as laid out in the CON submission; (2) the Department of Health and Human Services will make no changes to the CON submissions and approve the application as filed; (3) the CON project would have cost precisely

[9] Moreover, Mercer modified its CON/CIF methodology immediately before the hearing, thus providing no opportunity for intervenors to gather rebuttal testimony from the hospitals with the purported CON/CIF savings. Furthermore, if as the Board suggests intervenors could have provided testimony from the hospitals with the purported savings, it begs the question where is the affirmative testimony from DHA from those hospitals that their CON decisions indeed were based on Dirigo?

the amount calculated in the submissions; and (4) the CON projects that are withdrawn would have resulted in a net cost to the system.

As explained by Mr. Michaud, hospitals amend their applications for CON projects routinely for a variety of reasons, including shift in project scope, increase (or decrease) in construction costs, and advances in technology or treatment practice during the period of construction. (Michaud Prefiled, A.R. at 4313, lns. 15-21) Indeed, Catherine Cobb, DHA's state witness on CON/CIF, conceded that hospitals modify or withdraw CON applications for a wide variety of reasons, unrelated to Dirigo:

> A. [By Ms. Cobb] For an example, an example might be where someone simply changed their mind, they're not going to proceed with the project.
>
> Q. So they could have executed a letter of intent and just simply decide to forego the project?
>
> A. Correct.

(Hearing Testimony of Catherine Cobb ("Cobb"), A.R. at 5036, Tr. 255, lns. 7-12.)

In addition, Ms. Cobb could not say whether any of the four projects identified as "savings" in the CON/CIF initiative would have even passed the "needs" test that has been a part of the CON process since long before the effective date of the Dirigo Act. (*See, e.g., id.,* A.R. at 5035, Tr. 251, lns. 22-25.) Moreover, attributing "savings" to projects that were not slated to incur any costs whatsoever in the measuring year (and, indeed, have incurred no costs to date) is unreasonable and speculative. (*See, e.g., id*., A.R. at 5035-5036, Tr. 252, ln. 1- Tr. 253, ln. 5.) If there are truly cost savings, they will be in future years, and counted in that future year's CMAD.

The credibility of Mercer's CON/CIF initiative is further called into question by the fact that it was (1) essentially developed over the course of one weekend, just days before the Board hearing and (2) developed by Mercer, who conceded they lack any expertise in CON/CIF. Each point is briefly discussed below.

In its original year 2 analysis, filed on March, 20, 2006, Mercer submitted a CON/CIF methodology that proposed to aggregate CON/CIF projects to create a historical average and, from that, attempt to discern whether actual CON/CIF activity in the measuring period demonstrates "savings."

The year 2 methodology produced at hearing, however, "was developed as a result of the judge's order that the date be moved up and the hearing officer's request that the hearing be held not only on methodology but also on savings calculations." (Schramm, A.R. at 5047, Tr. 299, lns. 4-7.) The Hearing Officer's order referenced by Mr. Schramm was issued on Friday, April 28, leaving just three days to develop the new calculation by the deadline of May 2. Perhaps it is not surprising that a calculation put together in this short timeframe suffers from the numerous fundamental flaws outlined above.

With respect to qualifications, Mercer conceded it had no expertise in CON/CIF and, instead, relied upon Ms. Cobb for guidance on the CON/CIF measure:

> Q. . . . You're not, yourself, an expert by any means? From what you said earlier, I assume you would agree you're not a expert in Maine's Certificate of Need Act or its nuances or how it's applied here in the State of Maine, are you?
>
> A. No.
>
> Q. In fact, you relied on Kathy Cobb and the DHS staff to provide expertise on the CON process here in Maine?
>
> A. Correct.

(Schramm, A.R. at 5047, Tr. 300, lns. 12-22.)

Ms. Cobb, however, testified that she played little, if any, role in developing the methodology and, indeed, Ms. Cobb was only vaguely familiar with the fact that Mercer had changed the methodology for CON in between its initial testimony and the amended testimony filed immediately before the hearing:

> Q. Under the methodology that has been offered up here in this proceeding, the hospital that decides simply to for[e]go the project, that hospital's withdrawal of

> that letter of intent would be called savings attributable to the operation of Dirigo Health; is that right?
>
> A. [by Ms. Cobb] I'm not testifying about the methodology. That's not what I prepared to talk about.
>
> . . .
>
> Q. Were you aware that there was an earlier methodology for CON that was put forward [by Mercer]?
>
> A. There may have been, but I wasn't particularly involved with it.
>
> . . .
>
> Q. Do you have any understanding of what that original methodology was?
>
> A. No. . . . I didn't develop the methodology. . . .
>
> Q. Pardon me, I'm sorry for interrupting, but I want to focus more on the change from the original proposed CON methodology [from Mercer's original filing on March 20, 2006] to the one we have now. I want to understand the reasons why that occurred, to the extent you know.
>
> A. I think you need to talk to the consultants that developed the methodology, I provided input but I didn't do the calculations and I didn't develop the methodology.

(Cobb, A.R. at 5036, Tr. 255, lns. 13-20; A.R. 5037, Tr. 258, lns. 14-17; Tr. 258, ln. 22 – Tr. 259, ln.9.) Based on the testimony adduced at the hearing, it is clear that this CON/CIF methodology was developed both very quickly and in the absence of anyone with the requisite expertise.

For all of these reasons, the Board's CON/CIF recommendation should be rejected as not reasonably supported by the evidence in the record.

### C. Uninsured Savings Initiatives (Bad Debt and Charity Care, MaineCare Adult Expansion and Woodwork Effect Savings)

Anthem BCBS agrees that savings from a reduction or avoidance of bad debt and charity care and from increased enrollment as a result of an expansion in MaineCare eligibility for adults may be included in AMCS because they are specifically identified in the Dirigo Act. That said, the methodology recommended by the Board is inappropriate because it fails to consider available data concerning the number of uninsured persons in Maine and overstates cost

reductions from the uninsured initiatives by counting Dirigo Choice members as "uninsured" when clearly they are not.

More specifically, the year 2 methodology treats those who were DirigoChoice members during the first measuring year as though they had no insurance in year 1, and thus counts those members again when determining "savings" for the uninsured initiatives for year 2, notwithstanding that those members were not uninsured. (Hearing Testimony of Kevin Russell ("Russell"), A.R. at 4997, Tr. 97, lns. 4-8 ("for the 2005 savings, we counted the people who were in Dirigo in 2005. And when we get to 2006, we're counting the savings for the people who were in Dirigo in 2006, many of whom were enrolled in Dirigo in all or part of 2005").) This double counting is inappropriate because it assumes that those uninsured Mainers who enrolled in DirigoChoice in 2005 would have, in the absence of Dirigo, remained uninsured for another year. DHA's expert acknowledged the flaw in this assumption. (*Id.*, A.R. at 4997, Tr. 98, lns. 23 – Tr. 99, ln. 1 ("I'm sure that people go on and off insured ranks in states that don't have Dirigo, and I would assume that in the absence of Dirigo in Maine, that there would have been people who went on and off from being insured").)

Beyond the year 2 assessment, under the Board-adopted analysis DirigoChoice members will always be counted as uninsured, so "savings" will result, indeed will multiply, each year that there are enrollees in DirigoChoice, irrespective of whether they were truly uninsured prior to the measuring year or not (*i.e.* those who enrolled in DirigChoice in year 1 will be counted as uninsured for purposes of the uninsured savings initiatives not only for year 2, but for all subsequent years in which they remain DirigoChoice enrollees). Kevin Russell, Mercer's expert on the uninsured initiatives, confirmed the unlimited aggregation of this initiative at hearing:

> Q. The question is, you're counting people who were, in your view, uninsured prior to enrolling in Dirigo in 2005, right?
>
> A. Correct

Q. If that person remains enrolled in Dirigo today, you're counting them in your uninsured calculation?

A. We are.

Q. And you will continue to do that in perpetuity: am I understanding your methodology correctly?

A. We will count them as long as they're a Dirigo enrollee. I don't think anybody will be enrolled in Dirigo in perpetuity. We all die.

(*Id*., A.R at 4997, Tr. 99, lns. 13-24.)

A methodology that counts, and re-counts, savings by treating DirigoChoice members as "uninsured" until death is unreasonable.

**D. Health Care Provider Fee Savings Initiatives.**

**1. PIP Payments**

Any savings attributable to PIP payments, like CMAD and CON/CIF, should not be included in the year 2 AMCS calculation because increased PIP payments are not as a result of the operation of Dirigo Health or an expansion of MaineCare. Assuming, however, that the Superintendent determines that savings from PIP payments may be included in AMCS, the uncontroverted testimony of Steven Michaud establishes that only a small percentage of the payments should be included in the AMCS calculation.

The State is in arrears to hospitals for payments of over $200 million. (*See* Michaud, A.R. at 5146, Tr.65, lns. 5-12.) The "early" payment of PIP amounts that are included in Mercer's calculation do not reflect over-payments to hospitals, but instead are payments toward the very significant amounts that are already overdue. DHA suggests that these payments impact hospital cash flow—that is, when increased PIP payments are received, there is a decrease in the amount necessary for the hospital to borrow and thus a reduction in the need for hospital rate increases; that is, if the State pays hospitals more (but not all) of what they owe hospitals,

hospitals have "saved" money, and hospitals should use that "saved" money to reduce their charges.

Even assuming, *arguendo*, that such payments are within the ambit of the Dirigo Act and assuming further that the theory embedded in the DHA Board methodology is even plausible, MHA president Steve Michaud testified that PIP payments may enable some hospitals to decrease charges as a result of decreased borrowing, but historically that reduction in charges has been approximately only 4% of the amount of the PIP increase. (Michaud Prefiled, A.R. at 4312, lns. 8-14.) Based on this testimony—the only testimony in the record from a hospital representative as to the fiscal impact of increased PIP payments—it is unreasonable to attribute any more than 4% of the increase in PIP payments to the year 2 ACMS calculation.

**2. Increased Physician Payments**

Similarly, including the physician fee increase in the "savings" calculation is both illogical and illusory. If the physician fee increase is included in AMCS, that means the same amount would have to be included in the SOP, which can only be accomplished if insurance carriers are able to negotiate with physicians to decrease their charges in an amount equal to the physician fee schedule increase. (Hearing Testimony of Rebecca Wyke, A.R. at 5009, Tr. 146, lns. 15-22.) Even assuming that carriers will be able to negotiate with physicians to pass through their long-awaited increase in Medicaid rates, which in effect just allows them to lose less, there are no "savings" to the healthcare system in Maine; rather, the physicians will be in the exact same financial position as before the increase. This result, and the problems with DHA's proposed methodology, were highlighted in questioning of Sharon Roberts of Anthem BCBS:

> Q. I would like you to turn to Tab D of John Sheils' testimony which is the Hospital Study Commission report. . . . I have identified two paragraphs. Could you please read them into the record?
>
> A. Certainly.
>
> MR. LAUBENSTEIN: Could you identify the page you're on?

THE WITNESS: 62, Page 62.

A. "Medicaid payments to physicians, physicians which reportedly have not been increased on an across-the-board basis since 1983 also pose a major problem. The ramifications affect hospitals which often are required to provide care to Medicaid patients because doctors cannot afford to service the individuals. The commission believes every effort should be made to increase Medicaid payments to physicians as soon as possible but recognizes Maine's budgeting constraints. The commission also urges Maine's congressional delegation to work to maintain the Medicaid program's current funding mechanism as changes to the current mechanism could jeopardize both the financial health of Maine's hospitals and Mainer's access to health services."

Q. If the entire amount of the physician fee schedule is included in aggregate measurable savings and later included in the savings offset payment, would the result be that the physicians would have to, in effect, give that money to Anthem and other commercial payers that have to pay the savings offset payment?

A. I believe that to be correct.

Q. Then Anthem would have to, in turn, give that money to the Dirigo Health Agency in the form of a savings offset payment?

A. That's correct.

Q. Would the physicians have any more money under that scenario than they had before the physician increase?

A. No.

(Hearing Testimony of Sharon Roberts, A.R. at 5100, Tr. 34, lns. 16 – Tr. 36, ln.5.)

The Superintendent should reject this unworkable and inequitable methodology.

## III. Anthem BCBS's Alternative Methodology

As expressed above, Anthem BCBS believes that the Board-recommended methodology for the second assessment year is both unreasonable and contrary to the intent of the Dirigo Act because it overstates cost savings and then compounds the error by automatically attributing all such "savings" to Dirigo. Accordingly, Anthem BCBS requests that the Superintendent deny or modify the Board-recommended calculation of AMCS; to do otherwise would not only be unfair to Mainers with private medical coverage, but also unlawful and discriminatory.

Anthem BCBS presented to the Board a proposed methodology that starts with the principles embodied in the Superintendent's Decision and Order from the first assessment year,

with certain modifications that are consistent with the Superintendent's guidance therein. Reserving all rights on whether the CMAD initiative is a valid measurement of AMCS within the Dirigo Act, Anthem BCBS proposes an alternative methodology that (1) removes from the calculation of AMCS results that are expected, (2) provides a mechanism for verification that calculated savings are truly as a result of the operation of Dirigo Health and not other factors, (3) reduces the ability to manipulate results, (4) bases savings on charges, rather than hospital costs that may or may not lead to savings to private payers, (5) avoids overlapping savings measures that tend to result in duplicative savings, and (6) would impose on private payers only those savings that have accrued to private payers by explicitly accounting for those savings that are attributable to governmental payers.

Anthem BCBS's alternative methodology is explained in detail in the prefiled testimony of its expert Jack Keane (A.R. at 3111-36) as well as Anthem BCBS's Pre-hearing Brief in the Dirigo Board proceeding (A.R. at 497-502), and Anthem BCBS will not repeat the description here. In short, Anthem's BCBS's proposed methodology accounts for naturally occurring fluctuations in hospital expenses and removes expected results from the calculation of AMCS by establishing a baseline corridor of expected expenses through comparing the annual increases or decreases in expenses per CMAD for each hospital compared to the change in HMBI for each of the years for which data is available prior to Dirigo. The difference between the HMBI and the change in the expense per CMAD would be recorded for each hospital for each pre-Dirigo year to establish the historical corridor of cost fluctuations during the pre-Dirigo period. This corridor is the band or range of experience within which hospital expense per CMAD increased and decreased during the pre-Dirigo period. This corridor thus establishes the expected range of cost growth for each hospital, unrelated to the operation of Dirigo Health.

Hospitals that experienced actual expenses within the expected corridor would be excluded from the calculation of AMCS because their expense growth kept pace with historical, pre-Dirigo expectations. Hospitals with actual expenses that were higher than the expected corridor would be excluded as well. However, hospitals with expenses that were lower than the expected corridor would be put into a group for further analysis to determine whether those reductions were as a result of the operation of Dirigo Health.

Anthem BCBS has explained throughout its testimony and pleadings at the Board proceeding that reduction in charges is the only means by which to measure whether private payers realize actual, rather than theoretical savings. As such, the corridor approach described above would focus on hospital charges rather than costs, giving the methodology the added benefit of capturing all potential cost savings.

At the Board hearing, DHA expressed concerns with Anthem BCBS's corridor methodology, including that establishment of the corridor was arbitrary and analysis of individual hospitals to confirm actual expenses would be too time consuming and expensive. To the contrary, as Anthem BCBS expert Jack Keane testified, the corridor is only as arbitrary as the Mercer data from which it was constructed; the same Mercer data that Mercer has used to establish the historical cost growth used in its methodology. (Keane, A.R. at 5178, Tr. 195, ln. 22 – Tr. 196, ln. 5.)

Mr. Keane also observed that DHA's contention that investigation of hospitals for savings would be too financially onerous under the corridor approach is misplaced. One of the prime reasons to establish a corridor is to minimize the amount of special investigation required to ensure that Dirigo "savings" are actually cost reductions experienced by Maine hospitals and, in turn, Maine's privately insured who pay the SOP. (*Id.*, A. R. at 5181, Tr. 208, lns. 18-23.)

DHA and the Board were also critical of Anthem BCBS's alternative because it failed to show savings for the second assessment period. It should come as no surprise, however, that a methodology that is designed properly does not reflect positive cost savings in a year in which hospital cost growth significantly exceeded the historical mean and historical average. If anything, this fact supports the legitimacy of Anthem BCBS's proposed alternative.

## CONCLUSION

For the reasons set forth above, the methodologies recommended by the Dirigo Board are fundamentally flawed and do not yield an accurate calculation of AMCS that comports with the Dirigo Act. As the Dirigo Act directs, the AMCS calculation should include those cost savings that are the result of the operation of Dirigo Health and expansions in MaineCare. The methodology and calculations of AMCS recommended by the Board do not follow the statutory mandate, include assumptions that inflate savings, and should be rejected.

DATED: June 23, 2006

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## CERTIFICATE OF SERVICE

The undersigned hereby certifies that on June 23, 2006, a copy of Anthem BCBS's Brief was served on each of the persons listed below.

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